REQUEST FOR ASSISTANCE

State Form 45442 (R / 11-94)

PLEASE PRINT OR TYPE

Please complete and return to:
WORKER'S COMPENSATION BOARD
ATTN: Ombudsman Division
402 West Washington Street, Room W196
Indianapolis, Indiana 46204

Indiana Worker's Compensation Board
Ombudsman Division
(317) 232-5922
1-800-824-COMP

EMPLOYEE INFORMATION	EMPLOYER INFORMATION
Name of employee	Name of employer
Address (*number and street*)	Address (*number and street*)
City, state, ZIP code	City, state, ZIP code
Telephone number ( )	Telephone number ( )
Social Security number *	County of employment
Date of accident (*month, day, year*)	**WORKER'S COMPENSATION INSURANCE COMPANY INFORMATION**
Check one: ☐ Currently receiving benefits	Name of company
☐ Benefits have been terminated	Address (*number and street*)
Date of termination (*month, day, year*)	City, state, ZIP code
☐ Have never received benefits	Telephone number ( )
Have you hired an attorney? **	Contact person(s)
If Yes, name and telephone number of attorney	

Briefly describe your complaint / dispute (*attach additional sheets if necessary*):

I hereby request the Ombudsman Division of the Worker's Compensation Board to investigate my complaint. I understand that the Ombudsman Division is not a replacement for legal counsel, and that any specific legal questions should be addressed to my attorney.

Signature of employee	Date (*month, day, year*)

* PRIVACY NOTICE: This agency is requesting disclosure of your Social Security number in accordance with IC 22-3-4-13. This disclosure is not mandatory and you will not be penalized for refusing.

** You have no obligation to employ legal counsel under the Indiana Worker's Compensation and Occupational Diseases Acts.